Patient Registration

Central Jersey URGENT Care

Thank you for choosing Central Jersey Urgent Care to take care of you and your loved ones. Please fill this out to the best of your ability. Return this paperwork, along with a photo ID and your insurance card (if applicable) to the front desk..

Last Name :	**First Name** :	**Middle Name:**

Birthdate: / /	**SSN #:** - -	**Male** **Female**

Marital Status: Single Married Civil Union Widowed Divorced Domestic Partner

Mailing Address:	**Home Phone** : ( )
City:	**Cell Phone** : ( )
State:	Email Address: This will be used for Discharge Instructions and to keep you up to date about our Urgent Care
Zip:	**Can We Leave Messages?** **Yes** **No**

Primary Care Physician:

Name of Pharmacy:
Address:

Employment Information	
Employer Name	
Mailing Address	**Employer Phone** ( )
City	**Are you here for a work related injury?**
State **Zip**	**If yes, when did incident occur?**

Primary Insurance Information	
Who is the primary cardholder of the insurance policy?	
Relationship to patient	Date of Birth / /
Phone Number ( )	

Other Information
How did you find out about Central Jersey Urgent Care?
What do you need to be seen for today?

YOUR PRIVACY

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Central Jersey Urgent Care's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and I request the following restriction(s) concerning the use of my personal medical information:

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

We only release protected health information to people you authorize. Please note if there is anyone you would like to pre-authorize to receive information on you, your financial arrangements or your course of treatment. Listed below are the people I would like to receive information:

Name
Relationship to patient
Information to release: ☐ Appointments at Central Jersey Urgent Care ☐ Appointments (referrals) at outside facilities ☐ Insurance and billing information ☐ Diagnostic testing results (labs, x-rays, MRIs, CTs, EKGs, etc.)

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Signed:_____ Date _____ Relationship to patient _____

FINANCIAL POLICY

PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

We offer a significant discount for patients who pay their entire balance in full at the time of the visit. We also offer payment plans for self-pay patients who cannot afford to pay the balance in its entirety at the time of service.

For patients with medical insurance, we cannot guarantee that your insurance carrier will pay for your visit, or that your visit will apply to your in-network benefits. We will, however, make every effort to ensure that your claim is paid at the best rate for you. After verification of benefits, if your annual deductible has been met, we will be glad to accept the co-insurance portion for services rendered. For your convenience, our staff will be glad to file your primary and secondary insurance claims; however, final responsibility is ultimately the patient's.

For Patients with Insurance

I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance left. I also authorize Central Jersey Urgent Care or my insurance company to release any information required to process my claims.

Signed _____ Date _____

For Patients without Insurance

I pledge to pay an up front amount of at least $100 for each visit. I understand that I am getting a discount today for my charges and that if I pay the amount in full on the date of service that my discount is higher. I understand that getting monthly bills is a privilege and I pledge to pay my bill in full within three months of my office visit.

Signed _____ Date _____